ATLANTIC ORTHOPAEDIC SPECIALISTS
Leaders in Orthopaedic Health

Date: _____

Jennifer M. Byrd, MD
NEW PATIENT EVALUATION FORM
HIP

I. PATIENT DATA

Name: _____ Age: _____ DOB: _____

E-mail: _____ Occupation: _____

Telephone Number: _____ Referring Physician:_____

Cell Phone Number: _____ PCP: _____

Pharmacy: _____ Height: _____ Weight: _____

II. HISTORY OF YOUR PROBLEM

1. Which hip is the problem? Left Right
2. When did your symptoms begin? ___/___/____
3. Is your hip problem the result of an injury? Y / N
   a. If yes, is it (circle): Workman's Comp, Auto Accident, Litigation Pending
   b. Briefly describe injury: _____
      _____
4. Concerns (circle): Pain, Instability, Popping
5. Where is the pain located? (circle all that apply) GROIN / SIDE / BUTTOCKS / SUPERFICIAL / DEEP / OTHER:_____
6. Describe the pain (circle): Constant, Intermittent, Dull, Achy, Sharp, Burning, Throbbing, Tingling, Other:_____
7. Is the pain associated with (circle): clicking, catching, locking, popping, pain waking you at night, back pain, abdominal pain, other _____
8. Please rate the severity on a scale of 1 to 10: Now: _____ At it's worst: _____
9. What makes it better? (circle): Rest, Ice, Elevation, Medication, Other _____
10. What makes it worse? (circle): Prolonged sitting, Squatting, Running, Twisting, Changing direction, Walking distance, Other _____
11. Previous Treatment: _____
12. Previous Injury: _____
13. Previous surgery: _____
14. What activities are you involved in? (circle): football, basketball, soccer, volleyball, running, cycling, yoga, swimming, tennis, golf, other _____
    a. What level? (circle): high school, college, semi-pro, professional, recreational
    b. Frequency? _____

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III: PAST MEDICAL HISTORY

1. Have you ever had any of the following: Check all that apply, provide explanation in space below.

□ High Blood Pressure	□ Lung Disease	□ Autoimmune Disorder	□ Gout
□ High Cholesterol	□ Pacemaker	□ Liver Disease/Hepatitis	□ Stomach Ulcer
□ Diabetes	□ Arthritis	□ Fibromyalgia	□ Stroke
□ Neurological Disease	□ Anxiety/Depression	□ Blood Clot	□ HIV/AIDS
□ Kidney Disease	□ Cancer	□ Bleeding Disorder	□ Major Infection
□ Heart Disease	□ Sleep Apnea	□ Blood Transfusion	□ Thyroid Disease

Explain: _____
_____
_____

2. Have you had surgery before? What? _____
3. Allergies? _____
4. What medications and dosages are you taking? _____
   _____

IV: Social History

1. Occupation? _____
2. Do you smoke? _____ If so, how much? _____
3. Do you drink alcoholic beverages? _____ If so, how much? _____

Office Use Only:

	Left	Right
Trendelenburg		
Hip Flexion		
IR		
ER		
Ant Impinge		
Dynamic Labral stress		
FABER		
Post Impingement		
OBER		
Supine HF	/5	/5
Upright HF	/5	/5
Adduction	/5	/5
Abduction	/5	/5
Greater Troch		
Glut Med		
Piriformis		